White Salmon Family Practice

Cosmetic Dermatology
Informed Consent

DERMA FILLERS

By signing this consent form you are agreeing that you have been informed of known risks, benefits and alternatives related to receiving Derma Filler injections.

The Allergan family of derma fillers (Juvéderm, Voluma, Volbella and Vollure) are injectable gels that are sterile, biodegradable, non-pyrogenic, viscoelastic, clear, colorless, homogenized hyaluronic acid gel implants. It is approved by the United States Food and Drug Administration for the correction of moderate to severe facial wrinkles and folds, such as nasolabial folds and in most patients may last between one to two years depending on the product used.

Risks and complications that may be associated with Derma-Fillers and the implant procedures include, but are not limited to:

1. **Facial Bruising, Redness, Swelling, Itching and Pain**: I understand that there is a risk of bruising, redness, swelling, itching and pain associated with the procedure. These symptoms are usually mild and last less than a week but can last longer. Patients who are using medications that can prolong bleeding, such as aspirin, warfarin, or certain vitamins and supplements, may experience increased bruising or bleeding at the injection site. I understand that I should minimize exposure of the treated area to the sun or heat for approximately 24 hours after treatment or until any initial swelling or redness goes away.
2. **Nodules and palpable material**: I understand that there is a risk that small lumps may form under my skin due to the Derma Filler material collecting in one area. I also understand that I may be able to feel the Derma Filler material in the area where the material has been injected. **Migration**: I understand that the chosen Derma Filler, as with any filler material, may move from the place where it was injected.
3. **Infection**: As with all transcutaneous procedures, I understand that injection of any filler material carries the risk of infection.
4. **Allergic Reactions**: I understand that Derma-fillers should not be used in patients with severe allergies, a history of anaphylaxis, or history or presence of multiple severe allergies or hypersensitivity to any of the ingredients in the chosen Filler.
5. **Keloids/Scarring**: I understand that the safety of Derma-fillers in patients with known susceptibility to keloid formation or hypertrophic scarring has not been studied.
6. **Accidental Injection into a Blood Vessel**: I understand that Derma-fillers can be accidentally injected into a blood vessel, which may block the blood vessel and cause local tissue damage, or potentially even a heart attack or stroke.
7. **Duration of Effect**: I understand that the outcome of treatment with Derma-fillers will vary among patients. ***In some instances, additional treatments may be necessary to achieve the desired outcome.***

Uncertain Risks

- No studies of interactions of Derma-fillers with drugs or other substances or implants have been conducted.
- The use of Derma-fillers in patients under 18 years has not been established.

This above list is not meant to be inclusive of all possible risks associated with dermal fillers in general, as there are both known and unknown side effects and complications associated with any medication or dermal filler injection procedure. ***I understand that medical attention may be required to resolve complications associated with my injection.***

I understand and agree that all services rendered will be charged directly to me, and I am personally responsible for payment. By signing below, I acknowledge that I have read the foregoing informed consent, have had the opportunity to discuss any questions that I have with Provider Short to my satisfaction, and consent to the treatment described above with its associated risks. I understand that there is no guarantee of any particular results of any treatment.

I agree that pre- & post-procedure clinical photographs may be taken to monitor my treatment progress and for patient educational purposes. I understand that my identity will be protected.

I certify that I have read and understand the contents of this consent form. I have been given the opportunity to ask Provider Short any questions that I have about the procedure, and all of my questions have been answered. Provider Short has explained the procedure and its alternatives to me, and I both understand and accept the risks involved in this procedure.

Patient Name **Reviewed by: Debra Short, FNP**

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Date: ________________________ **Date:** ________________________